PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155780		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING (09/04/201)			ETED		
155780			B. WIN			09/04/2	2012
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE  ADISON AVE		
	N HEALTH CARE	CENTER			APOLIS, IN 46227		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
K0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	-	TAG	DEI ICIERCI I		DATE
KUUUU							
	Licensure and Q Walk-thru Surve Indiana State De	ode Recertification, State Quality Assurance ey were conducted by the epartment of Health in 142 CFR 483.70(a).	K00	000	This plan of correction is to serve as Madison Health Car Centers' credible allegation compliance.		
	Survey Date: 09 Facility Number Provider Number AIM Number: 2	r: 012225 er: 155780			Submission of this plan of correction does not constitute an admission by Madison Health Care Center or its' management company that the		
	Surveyor: Mark Code Specialist	c Caraher, Life Safety		allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and			
	Health Care Cercompliance with Participation in CFR Subpart 48 Fire and the 200 Fire Protection Life Safety Cod Existing Health	ety Code survey, Madison nter was found not in n Requirements for Medicare/Medicaid, 42 33.70(a), Life Safety from 00 edition of the National Association (NFPA) 101, e (LSC), Chapter 19, Care Occupancies and			other services in this facility Nor does this submission constitute an agreement or admission of the survey allegations.		
	be of Type III (2 sprinklered. Th system with smo corridors and in	acility was determined to 200) construction and fully e facility has a fire alarm oke detection in the all areas open to the acility has battery operated					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE CO A. BUILDING B. WING	01	— COM 09/0	E SURVEY PLETED 4/2012
	PROVIDER OR SUPPLIER		7465 M	ADDRESS, CITY, STATE, ZIP ( ADISON AVE APOLIS, IN 46227	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	rooms. The faci	in all resident sleeping lity has a capacity of 130 s of 62 at the time of this				
	1	found in compliance with rd to sprinkler coverage tor coverage.				
	access were spring providing facility	pt for the detached shed				
		Robert Booher, Life Safety dical Surveyor on 09/06/12.				
	with the aforeme	found not in compliance entioned regulatory evidenced by the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ21

Facility ID: 012225

If continuation sheet

Page 2 of 10

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 01	(X3) DATE ( COMPL		
	155780		A. BUII B. WIN			09/04/	2012
NAME OF D	DOLUDED OD GUDDU IED		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADISON AVE		
MADISOI	N HEALTH CARE C	CENTER		INDIAN	IAPOLIS, IN 46227		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG K0029	NFPA 101	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT)		DATE
SS=B	LIFE SAFETY CO	DDE STANDARD					
00 2		ed construction (with 3/4					
		ors) or an approved					
		inguishing system in					
		3.4.1 and/or 19.3.5.4 us areas. When the					
	-	tic fire extinguishing					
	• •	used, the areas are					
		ther spaces by smoke					
	• .	s and doors. Doors are					
	_	on-rated or field-applied that do not exceed 48					
		ottom of the door are					
	permitted. 19.3						
	Based on observa	ation and interview, the	K00	29	K 029 It is the policy of the fac	ility	10/15/2012
	facility failed to	ensure 1 of 2 kitchen			to provide self-closing doors th		
	doors opening in	to the service corridor			will automatically close upon fi	re	
		ally or upon activation of			alarm system activation. The door identified was in the serv	rice	
		stem. Furthermore, doors			hallway into the kitchen. This		
	to hazardous area	as are required to latch			an employee area of the buildi	-	
	into the door fran	ne when closed to keep			only. An outside contractor ha		
	the door tightly o	closed to resist the			provided a bid to the facility to the equipment, supplies, and	gei	
	passage of smoke	e. This deficient practice			labor to fix the door. The bid h	nas	
	could affect staff	and visitors in the			been approved by the facility.		
	vicinity of the ki	tchen exit doors in the			The outside contractor has		
	service corridor.				ordered the parts and has confirmed that the work can be	۵.	
					completed by October 15, 201		
	Findings include	:			All self-closing doors will be		
					checked monthly basis with the fire drills to ensure the doors	е	
	Based on observa	ation with the			automatically release with the	fire	
	Maintenance Dir	rector during a tour of the			alarm activation. This will be	<del>-</del>	
		20 a.m. to 2:00 p.m. on			documented on the fire drill rep	port	
	_	st door in the set of two			form. The Quality Assurance		
		rs to the service corridor			Committee will monitor by reviewing the fire drill reports		
	was in the fully o	open position and not			monthly for continued		
	_	self closer or automatic			compliance.		
							<u> </u>

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ21

Facility ID: 012225

If continuation sheet

Page 3 of 10

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

I 15578∩		A. BUILDING  B. WING	01	COMPLETED 09/04/2012
	ROVIDER OR SUPPLIER  N HEALTH CARE CENTER	7465 MADI	RESS, CITY, STATE, ZIP CODE ISON AVE OLIS, IN 46227	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	door closer or a positive latching mechanism to latch the door into the door frame. Based on interview at the time of observation, the Maintenance Director stated the west door is normally kept closed and locked into the door frame with a bolt at the top of the door and is only opened to bring food carts into and out of the kitchen, but acknowledged the west door in the set of two kitchen doors opening into the service corridor did not self close and latch into the door frame.  3.1-19(b)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ21

Facility ID: 012225

If continuation sheet Page 4 of 10

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 01			COMPLETED	
		155780	B. WIN			09/04/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			7465 M	ADISON AVE		
	N HEALTH CARE C				APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG K0048	NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
SS=B	LIFE SAFETY CO	ODE STANDARD					
00-D		plan for the protection of					
		or their evacuation in the					
	event of an emerg	gency. 19.7.1.1					
	Based on record	review and interview, the	K00	)48	K048 It is the policy of the fac	ility	09/07/2012
	facility failed to	include the use of kitchen			to have a written plan for the		
	fire extinguishers	s in 1 of 1 written fire			protection of all residents in the event of an emergency. The	е	
	safety plans for t	the facility. LSC 19.7.2.2			written fire plan for the facility	has	
	requires written l	health care occupancy			been revised by the Administrator		
	fire safety plans	shall provide for the			for the use of the K-class fire		
	following:				extinguishing system in relationship with the use of the kitchen hood extinguishing		
	(1) Use of alarms	s					
	* /	of alarm to the fire			system. The revised changes to the plan were reviewed at an education session with all staff		
	department						
	(3) Response to a	alarms					
	(4) Isolation of fi				on 9-7-12. The safety commit will review the fire and disaste		
		f immediate area			plan on a quarterly basis to	ı	
	` '	f smoke compartment			ensure that all policies protect	the	
		of floors and building for			residents in the event of an		
	evacuation				emergency. The monthly safe	ty	
	(8) Extinguishme	ent of fire			committee minutes will be reviewed by the Quality		
	` '	actice affects staff and			Assurance Committee to ensu	re	
	-	cinity of the kitchen.			continued compliance.		
	visitois in the VIC	onity of the kitchen.			Correction Date 9-7-12		
	Findings include	:					
	<u> </u>						
	Based on review	of the "Fire Prevention"					
	and "General Ac						
		with the Maintenance					
		record review from 9:30					
	•	n. on 09/04/12, the					
		fire safety plan did not					
	address the use of						
		d the K-class fire					
	camiguishers all	u mo ix-olass inc					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ21 Facility ID: 012225

If continuation sheet Page 5 of 10

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

155780		A. BUILD B. WING		<u>01</u>	COMPL 09/04/	ETED	
	PROVIDER OR SUPPLIER	TER		7465 MA	DDRESS, CITY, STATE, ZIP CODE ADISON AVE APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	interview at the time Maintenance Director written fire safety planot include the police overhead hood extinal suppress a fire befor	e use of the kitchen ing system. Based on to of record review, the or acknowledged the an for the facility did y to activate the guishing system to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ21

Facility ID: 012225

If continuation sheet Page 6 of 10

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155780	B. WING			09/04/	2012
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			7465 M	ADISON AVE		
MADISON	N HEALTH CARE C	CENTER		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0052	NFPA 101	DE CTANDARD					
SS=F	LIFE SAFETY CC						
	installed, tested, a	m required for life safety is					
		NFPA 70 National Electrical					
		72. The system has an					
	approved mainter	nance and testing program					
		oplicable requirements of					
	NFPA 70 and 72.						
		ervation and interview,	K00	52	K052 It is the policy of the fac	ility	10/15/2012
	•	l to maintain 1 of 71			to place and maintain smoke detectors in accordance with		
	smoke detectors	in accordance with			NFPA72. 1) This deficient		
	NFPA 72. NFPA	A 72, 2-3.5.1 requires in			practice could affect an area th	nat	
	spaces served by	air handling systems,			has 28 resident beds. An outs		
	smoke detectors	shall not be located			contractor has provided a bid t	0	
	where airflow pr	events operation of the			the facility to get one smoke detector moved that is within 3		
	detectors. NFPA	72, A-2-3.5.1 explains			feet from a return air opening.	•	
	smoke detectors	should not be located in			The bid has been approved by	,	
	a direct airflow r	or closer than 3 feet			the facility. The outside		
	from an air supp	ly diffuser or return air			contractor has confirmed that t	he	
	opening. This de	eficient practice could			work can be completed by October 15, 2012. The		
	affect 28 residen	ts, staff or visitors in the			maintenance supervisor will		
	vicinity of the Ko	ennedy Cove smoke wall			inspect all the smoke detectors		
	cross corridor do	oor set.			on a monthly basis. The smok	æ	
					detectors are part of the preventative maintenance		
	Findings include	:			program. The Quality Assurar	nce	
	C				Committee will monitor by		
	Based on observa	ation with the			reviewing the preventative		
		rector during a tour of the			maintenance logs quarterly. 2		
		20 a.m. to 2:00 p.m. on			A outside contractor has come into the building to performed t		
		oke detector in the			sensitivity testing on the 7 sm		
		the Kennedy Cove			detectors that were identified		
		s corridor door set was			the attic. Per National Fire Ala	ırm	
		iling within one foot of			Code NFPA 72, 7-3.2 the		
		•			sensitivity testing will be completed every alternate yea	r	
		nt. Based on interview at			The maintenance supervisor v		
	the time of obser	vation, the Maintenance			The maintenance dupor vidor v		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ21 Facility ID: 012225

If continuation sheet Page 7 of 10

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 09/04/2012
ENTER	7465 M	IADISON AVE	
TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE
ledged the smoke stridor next to the moke wall cross corridor ted on the ceiling within supply vent.			
ard review, observation e facility failed to ensure tectors were maintained th the applicable NFPA 72, National Fire PA 72, 7-3.2 requires ty shall be checked er installation and every reafter. After the second on test, if sensitivity detector has remained nd marked sensitivity nt obscuration light gray rked), the length of time on tests shall be extended to a maximum frequency is extended, or-caused nuisance quent trends of these naintained. In zones or in ance alarms show any previous year, shall be performed. moke detector is within ked sensitivity range, it ing any of the following			
	ENTER  ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  Ledged the smoke ATEMENT of DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  Ledged the smoke ATEMINATION INFORMATION INFOR	ENTER  ENTER  TAGE  TAGE	IDENTIFICATION NUMBER: 155780  A BUILDING 3, WING  TREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227  IDENTIFY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)  Redged the smoke rridor next to the moke wall cross corridor ted on the ceiling within supply vent.  Indianapolic in the compliance.  Indianapolic in the compliance of the property of the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ21

Facility ID: 012225

If continuation sheet Page 8 of 10

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155780		(X2) MULTIPLE CO A. BUILDING B. WING	01	COM	TE SURVEY MPLETED 04/2012			
NAME OF 1	PROVIDER OR SUPPLIEI	<b>.</b> {		ADDRESS, CITY, STATE, ZIP COD	E			
	N HEALTH CARE (			IADISON AVE				
				INDIANAPOLIS, IN 46227				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION		
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE		
	methods:							
	(1) Calibrated to	est method						
	(2) Manufacture	er's calibrated sensitivity						
	test instrument							
	(3) Listed contr	ol equipment arranged for						
	the purpose							
	(4) Smoke dete	ctor/control unit						
	arrangement wh	ereby the detector causes						
	a signal at the co	ontrol unit where its						
	sensitivity is out	side its listed sensitivity						
	range							
	(5) Other calibr	ated sensitivity test						
	methods approv	ed by the authority having						
	jurisdiction							
	Detectors found	to have a sensitivity						
	outside the listed	d and marked sensitivity						
	range shall be cl	eaned and recalibrated or						
	be replaced. Th	is deficient practice could						
	affect all resider	nts staff and visitors.						
	Findings include	<b>:</b> :						
	Based on review	of SafeCare "Sensitivity						
		on Report" documentation						
	-	with the Maintenance						
	Director during	record review from 9:30						
	a.m. to 11:20 a.r	m. on 09/04/12, each of						
	seven duct detec	etors located in the attic						
	throughout the f	acility were listed as						
	"NA" for the sm	oke detector sensitivity						
	test. In addition	, a review of SafeCare						
		t & Inspection Report"						
	_	lated 05/13/10 showed it						
	has been more th	nan two years since the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ21

Facility ID: 012225

If continuation sheet Page 9 of 10

PRINTED: 10/01/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155780		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 09/04/2012	
	PROVIDER OR SUPPLIE		7465 M	ADDRESS, CITY, STATE, ZIP CODE IADISON AVE IAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY OI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	tested. Based of Maintenance Diffacility from 11 09/04/12, seven in the attic through on interview at the Maintenance documentation of sensitivity testing was available for acknowledged if years since the acknowledged in the maintenance of the sensitivity testing was available for acknowledged if years since the acknowledged in the sensitivity testing was available for acknowledged in the sensitivity testing was available for acknowledged in the sensitivity testing was acknowledged in the sensitivity testing was acknowledged in the sensitivity testing acknowledged in the sensitivity testing was acknowledged in the sensitivity test	ctors were last sensitivity in observations with the rector during a tour of the 20 a.m. to 2:00 p.m. on duct detectors are located ighout the facility. Based the time of record review, e Director stated no of attic duct detector ig in the last two years or review and t has been more than two aforementioned duct tensitivity tested.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ21

Facility ID: 012225

If continuation sheet

Page 10 of 10